STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G100	A. BUILDING 00 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	6371 VERMONT ST MERRILLVILLE, IN 46410

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W0000	W0000 This visit was for a fundamental recertification and state licensure survey. Date of Survey: April 2, 3, and 4, 2012 Facility number: 000638 Provider number: 15G100 AIM number: 100233970 Surveyor: Tim Shebel, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/10/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview, the facility failed to assure 1 of 3 sampled clients (client #1) did not wear the same clothing two days in a row. Findings include: Client #1 was observed at the group home on 4/2/12 from 4:20 P.M. until 6:25 P.M., and on 4/3/12 from 6:02 A.M. until 7:30 A.M.. During both observations, client #1 wore same blue jeans and red sweatshirt. Direct care staff #1 was interviewed on 4/3/12 at 7:34 A.M.. Direct care staff #1 stated, "He (client #1) often wears the same clothes every day." Program director #1 was interviewed on 4/3/12 at 11:03 A.M.. Program director #1 stated client #1 did "sometimes refuse to change his clothing from day to day." 9-3-2(a)	W0137	Client #1 has a new behavior plan which addressed non-compliance. The plan will be modified to address this specific type of non compliance. It will be reviewed by his IDT, HRC and staff will be trained on modifications to BSP. Staff will also be trained on ensuring that all consumers wear clean clothing. Service Coordinator will ensure staff training is completed (5/4/12). To ensure future compliance Service Coordinator will continue to monitor consumers at least weekly for 60 days and at least bi-monthly thereafter.	05/14/2012

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to show evidence of thorough investigation of 2 of 5 injuries of unknown origin which involved 2 of 5 clients living at the group home (clients #2 and #4) and report findings to the administrator within five bushiness days for 1 of 5 injuries of unknown origin which involved 1 of 3 sampled clients (client #2). Findings include: 1. The facility's incident reports, from 9/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:34 P.M.. The review indicated the following injury of unknown origin involving client #2: "Date: 1-21-12, Name: [Client #2], Brief Description: I (direct care staff #7) went to check on guys (clients #1, #2, #3, #4, and #5.) [Client #2] was trying to get out of [client #3's] room. I turned on hallway light & saw [client #2's] face was bruised & scraped. I cleaned & put antibiotic on his face." Cause of this Incident/Accident: "I (direct care staff #7) am not certain what caused his (client #2's) injuries." The	W0149	Service Coordinator will retrain Program Specialist on documentation and reporting requirements of injuries of unknown origin and agency policy on abuse and neglect investigations. (5/14/12) To ensure future compliance Program Specialist, Service Coordinator, Behavioral Health Director, and/or Director of Nursing will monitor all incident reports to assess need for investigation at least weekly.	05/14/2012

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	"outcome" of a cursory investigation, dated 1/30/12 indicated "Client (client #2) was climbing out of another client's bed and caused scratches & abrasions to L (left) side of his face. Staff cleaned area with Peroxide." Further review of the 1/30/12 "outcome" of the investigation into client #2's injuries failed to show evidence of how the facility concluded client #2's injuries were caused by crawling on the floor to get to his own bed. The outcome into the investigation of the 1/21/12 incident further indicated the facility's administrator was not notified of the "outcome" of the cursory investigation until 1/30/12. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M.. Nurse #1 indicated direct care staff on duty put client #2 in the wrong bed. Nurse #1 further indicated she investigated the incident but failed to thoroughly document her findings and also indicated the results of the investigation into the 1/21/12 incident were not available to the administrator until 1/30/12. 2. The facility's incident reports, from 9/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:34 P.M.. The review indicated the following injury of unknown origin involving client #4: "Date: 1/13/12, Name: [Client #4], Brief Description:			

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	[Client #4] came home with his left cheek red and swollen and his eye was blood shot. Staff (direct care staff #8) checked about 2 hrs later and it (swelling) had gone down and the redness went away. Could have been reaction (sic) to something. " Cause of this Incident/Accident: "Unknown - did not have it when he (client #4) left this morning but returned with it. Went away after a couple of hours." A 1/19/12 follow up report by the program specialist indicated the cause of client #4's red and swollen face and bloodshot eye as follows: "Client (client #4) has hx (history) of seasonal allergies, Redness in the eyes & swelling of the cheek subsided within two hours. No treatment required." Further review indicated a conclusion, of the same incident, by the nurse as follows: "Client (client #4) cut himself on the nose while shaving. Staff cleaned area with Peroxide & and applied oint (ointment.)" Further review of the investigation into the 1/13/12 incident failed to show evidence of a thorough investigation and what the one possible cause client #4's red, swollen face and blood shot eye. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M.. Nurse #1 indicated she was unaware of another conclusion by the program specialist. Nurse #1 further			

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	indicated she investigated the incident but failed to thoroughly document her findings. The facility's records were further reviewed on 4/4/12 at 10:40 A.M.. Review of the facility's "Policy for Handling Cases of Neglect and Abuse", dated 12/20/2006, indicated, in part, the following: "III. All allegations will be investigated per the facility's investigation process." 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to assure evidence of a thorough investigation for 2 of 5 injuries of unknown injuries for 2 of 5 clients living in the group home (clients #2 and #4). Findings include: 1. The facility's incident reports, from 9/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:34 P.M.. The review indicated the following injury of unknown origin involving client #2: "Date: 1-21-12, Name: [Client #2], Brief Description: I (direct care staff #7) went to check on guys (clients #1, #2, #3, #4, and #5.) [Client #2] was trying to get out of [client #3's] room. I turned on hallway light & saw [client #2's] face was bruised & scraped. I cleaned & put antibiotic on his face." Cause of this Incident/Accident: "I (direct care staff #7) am not certain what caused his (client #2's) injuries." The "outcome" of a cursory investigation, dated 1/30/12 indicated "Client (client #2) was climbing out of another client's bed and caused scratches & abrasions to L (left) side of his face. Staff cleaned area with Peroxide." Further review of the	W0154	All staff will be retrained on documentation and reporting requirements of injuries of unknown origin, and agency policy on abuse and neglect investigations. (5/14/12). To ensure future compliance Program Specialist, Service Coordinator, Behavioral Health Director, and/or Director of Nursing will monitor all incident reports to assess need for investigation at least weekly.	05/14/2012

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	1/30/12 "outcome" of the investigation into client #2's injuries failed to show evidence of how the facility concluded client #2's injuries were caused by crawling on the floor to get to his own bed. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M.. Nurse #1 indicated direct care staff on duty put client #2 in the wrong bed. Nurse #1 further indicated she investigated the incident but failed to thoroughly document her findings. 2. The facility's incident reports, from 9/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:34 P.M.. The review indicated the following injury of unknown origin involving client #4: "Date: 1/13/12, Name: [Client #4], Brief Description: [Client #4] came home with his left cheek red and swollen and his eye was blood shot. Staff (direct care staff #8) checked about 2 hrs later and it (swelling) had gone down and the redness went away. Could have been reaction (sic) to something. " Cause of this Incident/Accident: "Unknown - did not have it when he (client #4) left this morning but returned with it. Went away after a couple of hours." A 1/19/12 follow up report by the program specialist indicated the cause of client #4's red and swollen face and bloodshot eye as			

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	follows: "Client (client #4) has hx (history) of seasonal allergies, Redness in the eyes & swelling of the cheek subsided within two hours. No treatment required." Further review indicated a conclusion, of the same incident, by the nurse as follows: "Client (client #4) cut himself on the nose while shaving. Staff cleaned area with Peroxide & and applied oint (ointment.)" Further review of the investigation into the 1/13/12 incident failed to show evidence of a thorough investigation and what the one probable cause of client #4's red, swollen face and blood shot eye. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M.. Nurse #1 indicated she was unaware of another conclusion by the program specialist. Nurse #1 further indicated she investigated the incident but failed to thoroughly document her findings. 9-3-2(a)			

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to notify the administrator of results of an investigation into 1 of 5 incidents of injuries of unknown origin which involved 1 of 5 clients living in the group home (client #4). Findings include: The facility's incident reports, from 9/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:34 P.M.. The review indicated the following injury of unknown origin involving client #2: "Date: 1-21-12, Name: [Client #2], Brief Description: I (direct care staff #7) went to check on guys (clients #1, #2, #3, #4, and #5.) [Client #2] was trying to get out of [client #3's] room. I turned on hallway light & saw [client #2's] face was bruised & scraped. I cleaned & put antibiotic on his face." Cause of this Incident/Accident: "I (direct care staff #7) am not certain what caused his (client #2's) injuries." The "outcome" of a cursory investigation, dated 1/30/12 indicated "Client (client #2) was climbing out of another client's bed	W0156	The Behavioral Health Director, Service Coordinator or delegated professional staff shall review all incident/accident reports to assess the need for investigations. An investigator will be assigned when required. Upon completion, the investigation shall be provided to the responsible administrator. (5/4/12) To ensure future compliance the Service Coordinator and Behavioral Health Director shall review all incidents to assess the need for investigations. Investigations will be completed as required.	05/04/2012

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	and caused scratches & abrasions to L (left) side of his face. Staff cleaned area with Peroxide." The results of the investigation of the 1/21/12 incident further indicated the facility's administrator was not notified of the "outcome" of the cursory investigation until 1/30/12. Nurse #1 was interviewed on 4/3/12 at 10:52 A.M.. Nurse #1 indicated direct care staff on duty put client #2 in the wrong bed. Nurse #1 further indicated the results of the investigation into the 1/21/12 incident were not available to the administrator until 1/30/12. 9-3-2(a)			

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W0441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview, the facility failed to conduct evacuation drills for 4 of 4 clients living at the facility (clients #1, #2, #3, and #4) during over night hours. Findings include: The facility's evacuation drills, from 4/1/11 to 4/2/12, were reviewed on 4/2/12 at 1:48 P.M.. The review failed to indicate clients #1, #2, #3, and #4 participated in evacuation drills, during over night shift, from 9:00 P.M. until 5:45 A.M., during the review period. Area Manager #1 was interviewed on 4/3/12 at 12:14 P.M.. Area Manager #1 stated, "We didn't conduct an over night evacuation drill during the last year." 9-3-7(a)	W0441	The Area Manager will retrain Direct Support Professionals on the timeframes for the different shifts as required by the evacuation drills. Training is to include varying the time of the evacuation drills and making sure that the time of the drill is clearly within the shift required, paying special attention to the timeframes at the end of the third shift and the beginning of the first shift. The Area Manager will be present for the first evacuation drill after retraining to insure that all staff are informed and able to carry out the necessary evacuation drills. (5/14/12) To insure future compliance the Area Managers will monitor evacuation drills twice per month for three months, then at least monthly thereafter. The tracking system for monitoring evacuation drills will be reviewed monthly to insure timeliness of training and drill.	05/14/2012